to prevent the silkworm gut from burying itself in the skin, at the same time permitting the inspection of the wound, which cannot be obtained

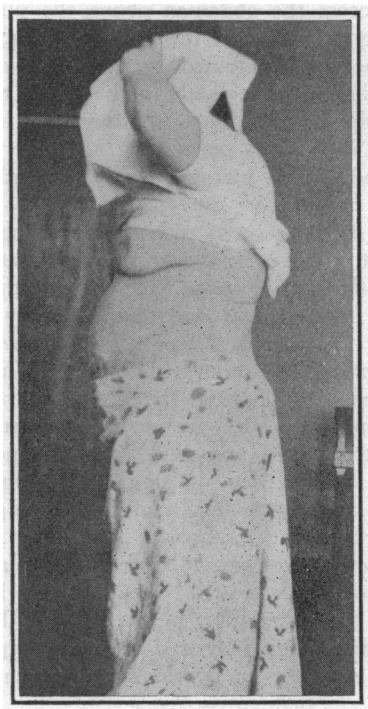

Figure IV

if the sutures are tied over a bolster of gauze. There is no occasion to employ drainage in these cases, and I object to its use, as I do in all clean

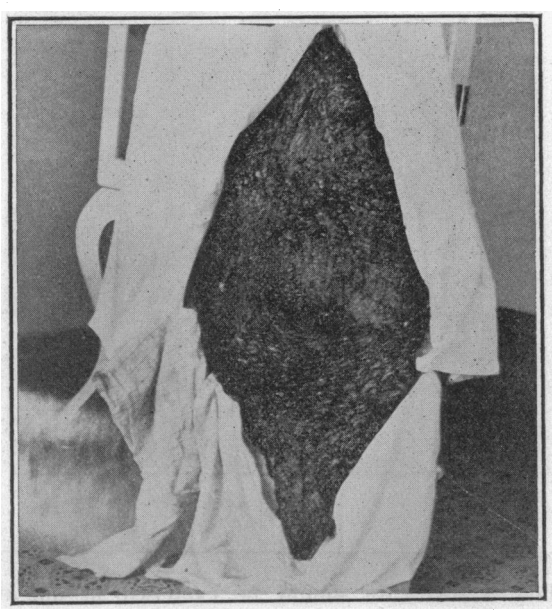

Figure V

wounds. I do advise, however, a daily inspection of the wound and the introduction of a grooved director between stitches if there be any accumulation of serum present. A moderately snug abdominal bandage is applied over the dressing and the patient put to bed on a back rest so as to slightly flex the body.

Fig. 3 shows the insulating tubes five days after operation. Fig. 4 shows the patient two weeks after operation. Fig. 5 represents the shape of the specimen as removed. It was one yard and three inches long, one foot and a half wide, three inches thick at the edge and weighed seventeen pounds.

Although up daily, after the first two weeks, the patient was retained in the hospital for five weeks to make it possible for me to have complete control of her diet. At the time of her departure from the hospital she weighed one hundred and ninety pounds, which was seventy-five pounds less than her weight on entrance. Her waist measurement was eighteen inches less. She will be kept on a diet, which is reducing her at the rate of two and a half to three and a half pounds per week, until her weight reaches one hundred and forty pounds.

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REPORT OF CASE OF DOUBLE TUBAL PREGNANCY.

By DAVID HADDEN, M. D., Oakland.

I want to report in this paper a case of double tubal pregnancy and a case of hemato-salpinx with bleeding into the peritoneal cavity unassociated with pregnancy.

The first patient, a woman of 35, has been married five years, but so far has not been pregnant. The history previous to the present sickness gives nothing of value except that a year before marriage there was an acute attack of pelvic trouble lasting some weeks, the main symptoms being pain in the pelvis and fever. The woman up to the time of that attack had been in good health, since then has had more or less trouble with her periods and is on the whole rather run down, but with no symptoms of any definite type.

I saw the patient first after a diagnosis of tubal pregnancy had been made by the attending physician. She was then two weeks over her menstrual time, which was by no means unusual for her, the only difference being that she was more nervous than usual and somewhat inclined to hysterical attacks. She complained that the breasts had been a shade sorer than usual, but that was only relative, as she had always more or less soreness at the periods.

On the evening of June 19th the patient began to have a brownish discharge gradually getting more profuse. About midnight while at toilet a sharp tearing pain occurred in the right side with a feeling of faintness. From then until the following noon the pain was quite persistent being mostly in the lower right side of the abdomen and was accompanied by diarrhea and nausea. When these symptoms subsided the patient felt comparatively well except for the extreme tenderness over the lower abdomen.

Examination showed the breasts somewhat tender but not enlarged, Montgomery tubercles more marked than normal, but patient says they have

always been so, otherwise the breasts gave no suggestion of pregnancy.

Abdominal palpation gave tenderness over both inguinal regions with a greater rigidity on the left side. Pelvic examination showed a uterus somewhat enlarged, cervix soft, considerable enlargement of right tube with extreme tenderness. A soft boggy mass occupying the left broad ligament and only slightly tender to touch. A grumous discharge from uterus. A diagnosis of an intraligamentary ruptured tubal pregnancy on the left side with probably a hydrosalpinx on the right was made.

The operation showed the left broad ligament distended with blood from a ruptured hematosalpinx. On the right side a hemato-salpinx (unruptured) which at the time was considered to be a sympathetic condition or perhaps similar to the other case reported in these notes. The microscopical examination of the right tube showed, however, the presence of villi and though the examination of the left tube has so far not been made carefully, I feel justified in diagnosing the condition on that side as an intraligamentory rupture of a tubo-ovarian pregnancy. I know of no condition which would cause a hemorrhagic rupture unassociated with weakening of the tubal wall as occurs from the villi penetration.

The second case is one of a woman, 29 years of age, who up to the time of the attack here reported had been in good physical condition with nothing of value in the history except that she was married some time ago, but for some years has not been living with the husband. The attack commenced as an acute pelvic inflammation, the gross pathology presenting in the left tube.

A diagnosis was made of pyosalpinx, which was confirmed by another gynecologist, who kindly saw her for me while I was on a vacation. Expectant treatment was adopted and the pain, temperature and soreness gradually subsided, the left tube remaining enlarged. There had been no disturbance of menstruation and no symptoms pointing to a tubal pregnancy. Some two or three weeks after the onset of the trouble the patient was up, feeling fairly well and anxious to return to work.

Without permission she took a street car ride and returned home suffering intense pain in the left side. Locally the findings were unchanged for some days, but the temperature returned and the patient was generally in poor condition. This happened while I was out of town and on my return some days later I found on pelvic examination a large mass projecting in the cul de sac and made a diagnosis of pelvic abscess.

A posterior incision showed a large collection of clotted blood. The left tube much distended, high up and adherent. After the operation the patient's condition improved markedly, but fresh bleeding continued through the gauze packing. Twelve hours later a laparotomy was done and a large oozing hemato-salpinx was removed from the left side. The recovery was uneventful, drainage being continued from the cul de sac.

No question as to the condition was raised in either the consultant's or my mind until some time later when the patient denied absolutely, the possibility of a pregnancy being present. A careful microscopical examination of the tube made then showed no embryonic structures and the man who made the sections reported that it reminded him of a similar case of a nurse at Johns Hopkins where an exceedingly thorough examination showed no signs of pregnancy.

Oakland (NOT Santa Cruz) is the place of the Annual Meeting of the State Society, April 15, 16 and 17, 1913.

THE TECHNIC OF THE REMOVAL OF FOREIGN BODIES AND NEW GROWTHS FROM THE ESOPHAGUS.*

By W. P. MILLSPAUGH, M. D., Los Angeles.

This subject is a little bulky for a ten-minute paper and I shall begin immediately to use the pruning shears. That portion of it referring to new growths is an unknown field to me, and I shall leave it untouched. Malignant growths are almost the only ones found in the esophagus; their removal belongs to general surgery.

In discussing the removal of foreign bodies, I suppose some mention should be made of the older and well-known methods. But I shall give very little time to this part of the subject, for I believe that those older methods are so blind and uncertain and dangerous that they should be discarded in practically every case where esophagoscopy is available. The number of men employing esophagoscopy is increasing rapidly, so that in the near future this means of relief will be available in nearly all parts of the country. And while time is very important in these cases, it will frequently mean less danger to the patient to take the time necessary to reach an esophagoscopist than to try to remove the foreign body by the old means.

Among the old methods I shall speak of inversion, the induction of vomiting, the administration of more or less solid food; the use of the bougie, probang and coin-catcher; and of the esophageal forceps.

I suppose it does a child little harm to stand him on his head and try to shake out a swallowed foreign body, if that effort is not persisted in too long. And if the body is round and smooth I suppose it would do little harm to give emetics and thus try to eject the intruder. And, further, if it be known that the body is not only smooth but of such diameters that it could be forced into the stomach without great risk it would sometimes be permissible to administer solid food, in an effort to carry it along, or even to carefully push it along with a bougie. No doubt these old methods have frequently been crowned with success, and in certain cases are relatively free from danger. It is astonishing what the esophagus will sometimes tolerate, as well as the rest of the alimentary tract.

The probang and coin-catcher are ingenious devices, frequently successful in proper cases, but responsible also for much hidden and disastrous damage; they belong to a chapter in surgical history which should be closed. The same praise and the same condemnation belong to the esophageal forceps; by these I mean the curved or angled or flexible forceps which are introduced blindly and which bite blindly for their object. Who could know whether the resistance felt on withdrawing a body by such forceps was the resistance of the body against the esophageal wall or whether a portion of the wall itself was coming, and how could one tell whether the point or edge of a sharp body were perforating or lacerating the wall in its passage? Of course the fluoroscope properly

* Read before the Los Angeles County Medical Association, November, 1912.